

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

00377

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

3 yrs 2 mo 22 da

Hospital, institution, or street address where death occurred

Fairfield State Hospital

How long in hospital or institution?

3 yrs 2 mo 22 da

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Clement A. V. Adrian

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

81 2 18 hrs. min.

9. Birthplace

Amity Ohio

(Town, County, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

17. By train

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Jan 31st 1946 at 1-35 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 9th 1942, to Jan 31st 1946,

and that I last saw her alive on Jan 30th 1946.

Immediate cause of death

Cerebral Hemorrhage 1da

Due to

Due to Arteriosclerosis 6 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

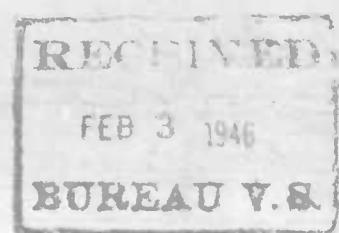
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 301

00378

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County CarrollCity or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos. 11 days

Hospital, Institution, or street address where death occurred:

Springfield State HospitalHow long in hospital or institution? 6 mos. 11 days

3. (a) FULL NAME

Florence E. Albrecht4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife William Albrecht7. Birth date of deceased (mo., day, yr.) 10/6/1891 6. (c) If alive, give age ? years8. AGE: Years 54 Months 3 Days 22 If less than one day hrs. min.9. Birthplace New Foundland (Town, county, and state)10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Pettis13. Birthplace New FoundlandMOTHER 14. Maiden name Heather15. Birthplace New Foundland16. Informant William AlbrechtAddress 8507 Greenwood Ave., Takoma Park17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 29, 1946 (month) (day) (year)Cemetery or crematory Washington, D. C.Location Washington, D. C.18. Funeral director R. J. GaffeyAddress 475 N. H. Washington D. C.19. Date rec'd by registrar Jan. 29, 1946 C. Perry (Signature) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Takoma Park (If outside city or town limits, write RURAL and give nearest town)Street No. 8507 Greenwood Avenue (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/29/46 19. 45 at 3:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7/18 19. 45, to 1/29 19. 46.and that I last saw h. alive on 1-28 19. 46.

Immediate cause of death

Psychosis with Syphilitic
Meningo-Encephalitis

DURATION

Known
May 1945

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

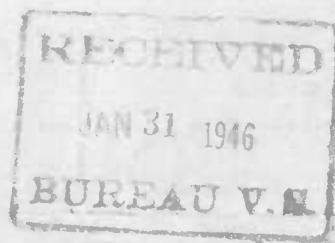
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE M. Virginia Beuer M.D. M. D. or otherSpringfield State Hospital Address Sykesville, Maryland Date signed 1/29/46



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 80

CERTIFICATE OF DEATH

06379

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 yrs. 5 mo. 9 da.

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 16 yrs. 5 mo. 9 da.

3. (a) FULL NAME

MARY A. AVIDIAN

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female white married

6. (b) Name of husband or wife (Unknown) Avidian

Unknown

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 21, 1888

8. AGE: Years Months Days If less than one day

57 10 28 hrs. min.

9. Birthplace Calvert County, Maryland

(Town, county, and state)

10. Usual occupation none

11. Industry or business none

12. Name William G. Cassard

13. Birthplace Baltimore, Maryland

14. Maiden name Edith Powell

15. Birthplace Calvert County, Maryland

Hospital Records

16. Informant

Address Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?)

Date thereof Jan 24, 1946
(month) (day) (year)

Cemetery or crematory St. Paul Cemetery

Location Mutual, Md.

18. Funeral director A. A. Hackney

Address Mutual, Md.

19. (Date rec'd by registrar) Jan 22, 1946

C. Harry Lee

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Prince Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18, 1946 at 8.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 22, 1931 to Jan. 18, 1946 and that I last saw her alive on Jan. 18, 1946

Immediate cause of death

Encephalitis (non epidemic)

DURATION

17 yrs

Due to

Due to

Psychosis with Organic
Broain Disease

17 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

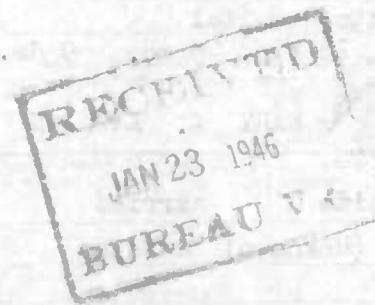
Injured at work?

23. SIGNATURE

Maud M. Rees, M.D.

M. D. or other

Address Sykesville, Md. Date signed 1-18-46



~~MR~~
Evidence for change of
age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

00380

FILM No. 100 JAN 28 1946, CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

Carroll
County.....
rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 5 years, 8 months
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution?..... 5 years, 8 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....
Baltimore City
City or town..... (If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)

3. (a) FULL NAME

George Barrett

3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced
male white single

8. (b) Name of husband or wife.....
..... 6. (c) If alive, give age..... years

7. Birth date of
deceased (mo. day, yr.) December 15, 1908

8. AGE: Years..... Months..... Days..... If less than one day
36 37 1 6 hrs. min.

9. Birthplace..... Wilmington, Delaware
(Town, County, and state)

10. Usual occupation..... paperhanger

11. Industry or business

12. Name..... Allan E. Barrett
13. Birthplace..... Maryland

14. Maiden name..... Adeline Mellor
15. Birthplace..... Maryland

16. Informant..... Springfield State Hosp. records
Address..... Sykesville, Maryland

17. Burial..... Jan 24 1946
(Burial, cremation, or removal. Which?) Date thereof.....
(month) (day) (year)

Cemetery or crematory..... St. John Cemetery
Location..... Ellicott City, Md.

18. Funeral director..... Easton Ford
Address..... Ellicott City, Md.

19. Jan. 21, 1946, J. C. Harry Green
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 21 1946, at 5:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 1 1943, to Jan. 21 1946,
and that I last saw him alive on January 20 1946.

Immediate cause of death.....
Bronchopneumonia

DURATION

24 hours

Due to.....

Due to.....

Other conditions..... Schizophrenia, paranoid
type 8 yrs.

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

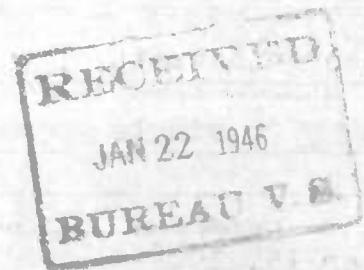
Means of injury..... Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE Robert Bertrand May, M.D.

Springfield State Hospital M.D. or other

Address..... Sykesville, Maryland Date signed 1-21-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12-12

00381

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County Carroll

City or town Sykesville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 1 day

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 1 month, 1 day

3. (a) FULL NAME

Samuel Edward Beeler

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

B. (b) Name of husband or wife

Ruth Catherine Beeler

7. Birth date of deceased (mo., day, yr.)

August 7-1876

B. (c) If alive, give age

52

years

8. AGE:

69

Years

Months

5

Days

6

If less than one day

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Mechanical Engineer

11. Industry or business

Samuel Beeler

12. Name

Maryland

13. Birthplace

Rachel Funkhauser

14. Maiden name

Virginia

15. Birthplace

Ruth B. Beeler

16. Informant

63 Broadway, Hagerstown, Md.

17. (Burial, cremation, or removal. Which?)

Burial Date thereof 1/16/46

(month) (day) (year)

Cemetery or crematory

Rest Haven Cem.

Location

Hagerstown, Md.

18. Funeral director

F. K. Goffman

Address

Hagerstown, Md.

19. (Date rec'd by registrar)

Jan. 14 1946

C. Harry New

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 63 Broadway

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

January 13 1946, at 12:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 12 1945, to January 13 1946,

and that I last saw him alive on January 13 1946.

Immediate cause of death

Acute Suppurative Nephritis and Pyelonephritis Acute Cystitis Acute Peritonitis due to above (direct extension).

Due to

Unknown

Other conditions

Pyelitis with Cerebral Anterior Seizures

(Include pregnancy within 8 months of death) 12-12-45

Major findings of operations Herniorrhaphy Date of op. Jan 3-1946

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

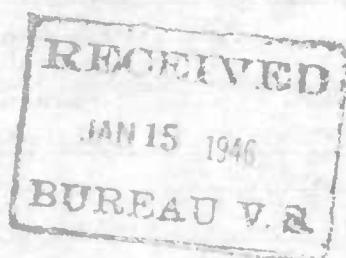
Means of injury Injured at work?

23. SIGNATURE M. Virginia Beeler M.D.

M. D. or other

Address Sykesville, Md.

Date signed Jan 13-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 102

CERTIFICATE OF DEATH

Reg. Dist. No. 80

06582

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Catherine Benedict

4. Sex:

5. Color or race:

6. (a) Single, married, widowed, or divorced:

female white widow

6. (b) Name of husband or wife:

Samuel W. Benedict

7. Birth date of deceased (mo., day, yr.):

May 12-1857

6. (c) If alive, give age: years

8. AGE:

Years: 88

Months: 7

Days: 25

If less than one day: hrs. min.

9. Birthplace:

Carroll County, Md.

(Town, county, and state)

10. Usual occupation:

Housewife

11. Industry or business:

William C. Snelson

MOTHER FATHER

12. Name:

Sophia Fisher

13. Birthplace:

Maryland

14. Maiden name:

Sophia Fisher

15. Birthplace:

Maryland

16. Informant:

Escarine C. Benedict

Address:

New Windsor, Md.

17. (Burial, cremation, or removal) Which?

Burial Date thereof: Jan 11-1946

(month) (day) (year)

Cemetery or crematory:

Winters Cemetery

Location:

New Windsor, R. 4, S.

18. Funeral director:

H. H. Hartler & Sons

Phantom Bridge, New Windsor, Md.

19. (Date rec'd by registrar)

January 18, 1946

(Date rec'd by registrar)

Escarine C. Benedict

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State:

Maryland

County:

New Windsor

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2. (a) If veteran, name war:

3. (b) Social Security Number:

None

MEDICAL CERTIFICATION

20. DATE OF DEATH:

Jan 8, 1946, at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 15, 1945, to January 8, 1946, and that I last saw her alive on January 8, 1946.

Immediate cause of death:

Bronchopneumonia

Due to: Generalized Arteriosclerosis

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings or operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury:

Injured at work?

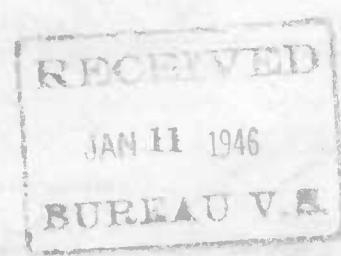
23. SIGNATURE:

James T. March, M.D.

M. D. or other

Address:

Wilmington, Md. Date signed: Jan 19, 1946



✓ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

00383

Reg. Dist. No. 74

CERTIFICATE OF DEATH

1. PLACE OF DEATH: Carroll
 County.....
 City or town..... rural near Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 45 yr., 6 mo., 24 days
 Hospital, Institution, or street address where death occurred:
Springfield State Hospital
 How long in hospital or institution? 45 yr., 6 mo., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County.....
 City or town..... Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war.....

3. (a) FULL NAME
Charles H. Bingel

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) unknown 6. (c) If alive, give age..... years

8. AGE: Years 69 Months Days If less than one day
 hrs. min.

8. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name Henry Bingel

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Springfield State Hosp. records

Address Sykesville, Maryland

17. Burial Burial Date thereof Feb 1 1946
 (Burial, cremation, or removal. Which?) Date (month) (day) (year)

Cemetery or crematory Springfield Hosp. Cem.
 Location Sykesville, Md.

18. Funeral director C Harry Wees
 Address Sykesville, Md.

19. Feb 1 1946 C Harry Wees
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 1946 at 1:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to Jan. 31 1946 and that I last saw him alive on January 31 1946

Immediate cause of death Acute suppurative nephritis DURATION 2 wks.

Due to Acute cystitis 1 mo.
Chronic myocarditis and myo-
cardial degeneration prior to
1946

Other conditions Dementia precoox, hebe-
phrenic type, prior to 1900
 (Include pregnancy within 3 months of death)

Major findings or operations Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

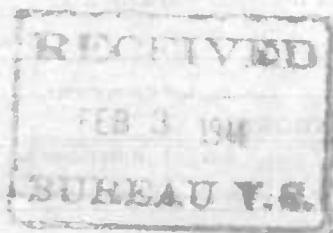
Means of injury Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE Robert Bertrand May, M.D. M.D. or other

Springfield State Hospital

Address Sykesville, Maryland Date signed 1-31-46



PLEASE WRITE PLAINLY, USE UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 64

CERTIFICATE OF DEATH

Reg. Dist. No. 00384 80

1. PLACE OF DEATH: Carroll
County New Windsor

City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Rural
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Louise Blackstean

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of
deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years	Months	Days	If less than one day
4	19		hrs. min.

9. Birthplace

Carroll County, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

Clifton S. Blackstean

12. Name

MOTHER FATHER

Maryland

13. Birthplace

Ethel M. Fritz

14. Maiden name

Maryland

15. Birthplace

Clifton S. Blackstean

16. Informant

New Windsor Md. R. D.

Address

Burial Date thereof Jan 26-1946
(Burial, cremation, or removal. When?)

Cemetery or crematory

Fatherack Cemetery

Location

Elmwoodtown, Md.

18. Funeral director

W. H. Hartley & Sons

Address

Elmwood Bridge, New Windsor, Md.

19. On 26 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

Noel

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1946 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... 10... 19...

and that I last saw h. alive on

19...

Immediate cause of death status Sypmaticus

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

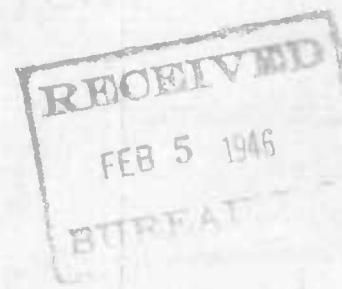
Means of injury

Injured at work?

23. SIGNATURE James T. O'Neal, Deputy Medical Examiner

Address Arbutus M. D. or other 7th

Date signed 1-24-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 945

00385

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Harry L. Bosley

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age.....years

June 19, 1872

8. AGE:

Years Months Days If less than one day

73

6

20

hrs.

min.

9. Birthplace.....

(Town, county, and state)

Maryland

10. Usual occupation.....

Farm Labor

11. Industry or business

MOTHER

FATHER

12. Name.....

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

(Date rec'd by registrar)

Thomas M. Bosley

Maryland

Annie M. Williams

Maryland

Mrs. John Bradbeck

Greenmount, Md.

Date thereof.....

(month) (day) (year)

cemetery

Greenmount, Md.

Location

David Winkler, Son

Address

Manchester, Md.

Registration

Date signed

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.....County.....

City or town.....(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Jan. 9

1946, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....to

19.....

and that I last saw h.....alive on

19.....

immediate cause of death.....

Coronary Occlusion

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

none

Date of op.

Autopsy results.....

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work.....

23. SIGNATURE.....

John S. Jones, Jr.

M. D. or other

Address.....

Westminster, Md.

Date signed

RECEIVED

JAN 14 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

00386 8

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred.....

Springfield State Hospital

How long in hospital or institution?.....

3. (a) FULL NAME

Joseph Brenneis

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M W

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

February 22nd 1868

8. AGE:

Years

Months

Days

If less than one day

XX hrs.

min.

9. Birthplace.....

(Town, county, and state)

Jarl

10. Usual occupation.....

Labour

11. Industry or business.....

Philippe Brenneis

MOTHER FATHER

12. Name.....

Philippe Brenneis

13. Birthplace.....

Germany

MOTHER

14. Maiden name.....

Catherine Borchardt

15. Birthplace.....

Md.

16. Informant.....

Charles Brenneis

Address

506 Orkney Rd Baltimore

17. Burial

(Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)

Cemetery or crematory

Holy Redeemer

Location

Belair Road Baltimore Md.

18. Funeral director.....

George J. Ruth Inc.

Address

1735 Hayford Ave

19. (Date rec'd by registrar)

19. (Date)

Unmarked

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Jarl

County.....

City or town.....

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

506 Orkney Rd

(If rural, give LOCATION)

2.(a) If veteran, name war.....

None

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 21st 1946 at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 14 1946 to Jan 21 1946 and that I last saw him alive on Jan 21st 1946

Immediate cause of death.....

Lobar Pneumonia 4 days

Due to.....

Chronic Hypertension 10 years

Other conditions.....

Hypertension

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE

J. H. Mastin M.D.

M. D. or other

Address.....

Date signed.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
24 days
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. East Middle Lane
(If rural, give LOCATION)

3. (a) FULL NAME
DAVID CLAGGETT

3. (b) Social Security Number
220-07-4146

4. Sex male 5. Color or race col. 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) December 20, 1903
8. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
42 0 24 hrs. min.

9. Birthplace Shady Grove, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name Sylvester Claggett
13. Birthplace Rockville, Md.

MOTHER
14. Maiden name Emma Hawkins
15. Birthplace Mount Zion, Md.

16. Informant Reuben Hoffman, M.D.
Address Henryton, Maryland

17. Burial Date thereof Jan 18 1946
(Burial, cremation, or removal (which?) Date thereof (month) (day) (year))

Cemetery or crematory Lincoln Park
Location Lincoln Park near Rockville

18. Funeral director Robert J. Snowden
Address Rockville Md.

19. Jan. 14, 1946
(Date rec'd by registrar) Albert B. Sanderlin
Deputy Local Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH January 14, 1946, at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 20, 1945, to Jan. 14, 1946, and that I last saw him alive on Jan. 14, 1946.

Immediate cause of death Pulmonary Tuberculosis
DURATION July 1945

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.

M. D. or other

Address Henryton, Md. Date signed 1-14-46

RECEIVED

JAN 18 1946

BUREAU V S

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3d

FILM No. 100 JAN 28 1946

00388

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County

City or town

Carroll

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 days 3 days

Hospital, institution, or street address where death occurred:

Hagerstown Hospital

How long in hospital or institution? 0 days 3 days

3. (a) FULL NAME

Virginia Lee Clark

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

J

W.

single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 12 - 1921

8. AGE:

Years 24

Months 2-3-

Days 3

It less than one day

Days 4

hrs.

min.

9. Birthplace

(Town, county, and state)

Cumberland

10. Usual occupation

11. Industry or business

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

Date

20. Date of death

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on

Immediate cause of death

Due to

Due to

Other conditions

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

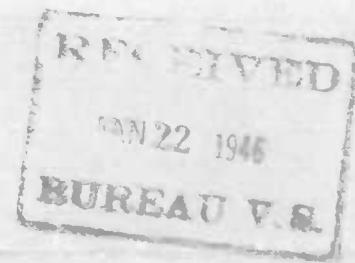
Address

Date signed

M. D. or other

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00589

75

Reg. Dist. No.

1. PLACE OF DEATH

County

Carroll

City or town

Manchester, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

7 weeks

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2 weeks

3. (a) FULL NAME

Rachel Irene Compton

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white Married

6. (b) Name of husband or wife

Francis W. Compton

7. Birth date of deceased (mo., day, yr.)

January 11 1919

6. (c) If alive, give age

34

years

8. AGE:

Years

Months

Days

If less than one day

27 0 7

hrs.

min.

9. Birthplace

Hampstead Md

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

Home

Tessley E. Jeffs

12. Name

Tessley E. Jeffs

13. Birthplace

Hampstead Md

14. Maiden name

Sarah Alice Reed

15. Birthplace

Manchester Md

16. Informant

Mrs. Tessley Jeffs

Address

Manchester Md

17. Burial

Cemetery

Date thereof 6 22 46

(Burial, cremation, or removal, Which?)

Date

Cemetery or crematory

Location

Manchester Md

18. Funeral director

Carol White Says

Address

Manchester Md

19. Date rec'd by registrar

Date rec'd by registrar

19. Date

Date

19. M. D. or other

Address

Date signed

1-18-46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Carroll

City or town

Manchester Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 18 1946, at 8 45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dec 26 1945 to Jan 18 1946

and that I last saw her alive on January 18 1946

Immediate cause of death

Subacute Bacterial Endocarditis

DURATION

?

Due to

Streptococcus Viridans

?

Due to

Streptococcus Viridans

?

Other conditions

Rheumatic Cardio-Vascular Disease

?

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

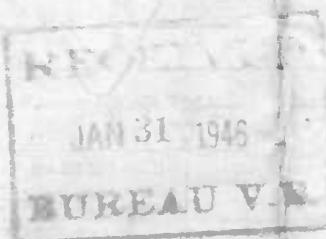
23. SIGNATURE

Joseph E. Bush, M.D.

M. D. or other

Address

Date signed



STATE OF MARYLAND—CERTIFICATE OF DEATH

00390

1. PLACE OF DEATH

County CarrollVillage or City Sykesville, Md.Length of residence in city or town where death occurred 60 yrs.

No.

(If death occurred in a hospital or institution, give its NAME instead of street and number) 131a St., Wardmos. ds. How long in U.S. if of foreign birth? ys. mos. ds.Registration Dist. No. 742. FULL NAME James Thomas Conaway(a) Residence No. Sykesville, Md. R. 1

(Usual place of abode)

St. Ward.

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Married

5a. If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Mary Ellen Triplett

6. DATE OF BIRTH (month, day, end year)

July 1, 1861

7. AGE

Years 83Months 6Days 19If LESS than
1 day, _____ hrs.
or _____ min.

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.Farmer9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.10. Date deceased last worked at
this occupation (month and
year) 194511. Total time (years)
spent in this
occupation 60

12. BIRTHPLACE (city or town)

(State or country)

Carroll County, Md.

FATHER

13. NAME

James B. Conaway

MOTHER

14. BIRTHPLACE (city or town)

(State or country)

Md.

15. MAIDEN NAME

Dorothy Stockdale

16. BIRTHPLACE (city or town)

(State or country)

Md.

17. INFORMANT

(Address)

James C. ConawaySykesville, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place

Date

19. UNDERTAKER

(Address)

J. Francis KeayWestminster, Md.

20. FILED

Date

21. SIGNATURE

Registrar

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

21. DATE OF DEATH

January 20, 1946

(Month)

(Day)

(Year)

22. I HEREBY CERTIFY. That I attended deceased from

1935

to

1946

I last saw him alive on Jan 20, 1946; death is said to have occurred on the date stated above, at 9:00 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Penile
chronic myopathy
dr. arteriosclerosis with
hypertension
chronic intestinal nephritis

Other Contributory Causes of importance:

Name of operation

Date of

What last confirmed diagnosis?

Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of injury 19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signatures)

(Address) Laurel, Maryland M. D.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	RECEIVED	1 week ago
Run over by street car	JAN 24 1940	1 week ago
Peritonitis		3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

00391

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County

City or town

Carroll

Sykesville

How long in above place of death?

1 yr 7 mos 28 days

Hospital, Institution, or street address where death occurred

Springfield State Hospital

How long in hospital or institution?

1 yr 7 mos 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Md. Montg Co.

Silver Spring

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

W. Married

William Crann

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age, years

8. AGE: Years

Months

Days

If less than one day

59 7 19

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Date thereof
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

Washington, D. C.

W. W. Chambers Co

1400 Chapin St. N.W. Wash. D.C.

C. G. Gray (Seal)

Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 7th 1946 at 5:45 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 10th 1944 to Jan 7th 1946

and that I last saw her alive on Jan 7th 1946

Immediate cause of death

Cerebral Hemorrhage

Due to

arterial Sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

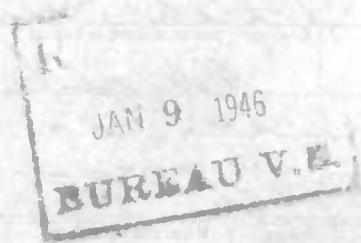
Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 472

00392

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Emma J. Curley

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F.

W. Divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo. day, yr.)

8. (c) If alive, give age... years

June 28, 1883

8. AGE:

Years Months Days If less than one day

62 6 3 hrs. min.

9. Birthplace

(Town, county, and state)

Md.

10. Usual occupation

None

11. Industry or business

12. Name

Frederick Wilson

13. Birthplace

Md.

14. Maiden name

15. Birthplace

Md.

16. Informant

Mrs. Dennis F. Ely

Address

Sykesville, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Jan. 3, 1946
(month) (day) (year)

Cemetery or crematory

Greenmount Cemetery

Location

Baltimore, Md.

18. Funeral director

C. Harry Ely

Address

Sykesville, Md.

19. Date

Jan. 2, 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md.

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 1st 1946 at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1st 1945, to Jan. 1, 1946

and that I last saw her alive on Jan. 31, 1945

Immediate cause of death:

Quinomia J. Ely

Due to:

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. A. Burns, M.D.

M. D. or other

Address: Sykesville, Md.

Date signed: Jan. 2, 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

Reg. Dist. No. 74

00392

1. PLACE OF DEATH:
County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 4 mos., 4 days.
Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 1 yr., 4 mos., 4 days.

3. (a) FULL NAME
Marshall D. DeConway

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife -----

7. Birth date of deceased (mo. day, yr.) July 1, 1893 6. (c) If alive, give age ----- years

8. AGE: Years 52 Months 6mos Days 18 If less than one day ----- hrs. ----- min.

9. Birthplace Illinois
(Town, county, and state)

10. Usual occupation Pharmacist

11. Industry or business Pharmacy

MOTHER FATHER 12. Name Elzear DeConway

13. Birthplace England

14. Maiden name Ida Featherstone

15. Birthplace New York

16. Informant Hospital records

Address General

17. Cemetery Date thereof Jan 22/46
(Burial, cremation, or removal? Which?) (month) (day) (year)

Cemetery or crematory St. Mary's

Location Annapolis Md.

18. Funeral director B. J. Murphy

Address Annapolis Md.

19. Jan 80 1946 C. Henry DeConway
(Date rec'd by registrar) (Year) (Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. Route 3
(If rural, give LOCATION)

2. (a) If veteran, name war -----

3. (b) Social Security Number -----

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19 1946 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1944 to Jan 19 1946

and that I last saw him alive on Jan 19 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 3 yrs

Due to -----

Due to -----

Other conditions Schizophrenia, Catatonic type ----- 21 yrs
(Include pregnancy within 3 months of death)

Major findings of operations ----- Date of op. -----

Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work? -----

23. SIGNATURE Arnold H. Eichet, M.D. M. D. or other -----

Address Springfield State Hospital, Annapolis Date signed 1-19-46

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00394

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 72

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Carroll

City or town Ames Mills
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME Charles Williams Dell

4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mabel Glose Dell

7. Birth date of deceased (mo., day, yr.) Oct. 7 - 1915

8. AGE: Years 30 Months 2 Days 28 If less than one day

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Hanner

11. Industry or business

12. Name Edgar Dell

13. Birthplace Md.

14. Maiden name Cora Buxton

15. Birthplace Md.

16. Informant Mabel Glose Dell

Address Washington Rd. Westminster, Md.

17. Burial Date thereof Jan. 8, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Kidderminster Cemetery

Location Westminster, Md.

18. Funeral director H. Bankard Son

Address Westminster, Md.

19. Jan. 7th, 1946 Date rec'd by registrar Calvin D. Bennett
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Westminster Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5, 1946 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 45 to Jan 5, 1946

and that I last saw h. m. alive on Jan 4, 1946

Immediate cause of death

carcinoma of all glands

Due to growin

Due to cause of liver

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

May Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? None (City or town) (County) (State)

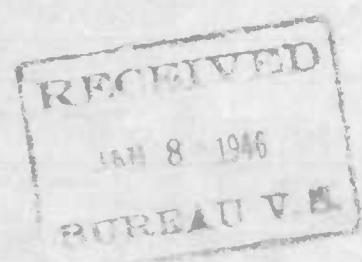
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE W. C. Germutus M. D. or other

Address Westminster, Md. Date signed 1-6-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73D

00395

CERTIFICATE OF DEATH

Reg. Dist. No. 82

1. PLACE OF DEATH: Carroll
County.....
City or town..... Ridgeville

(If outside city or town limits, write RURAL and give nearest town)

5 days

How long in above place of death?.....
Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME
BASIL DORSEY4. Sex
Male | 5. Color or race
Colored | 6.(a) Single, married, widowed, or divorced
WidowedB.(b) Name of husband or wife
deceased | Letticia Dorsey7. Birth date of
deceased (mo. day, yr.)
April 10, 18818. AGE: Years
64 | Months
8 | Days
23 | If less than one day
..... hrs. min.9. Birthplace
Carroll Co. Maryland(Town, county, and state)
Farmer

10. Usual occupation.....

11. Industry or business
Roderick DorseyMOTHER FATHER
12. Name
Maryland
13. Birthplace
Jemima14. Maiden name
Maryland15. Birthplace
Mrs. Alice M. Dorsey10. Informant
R.D. Mt. Airy, Md.Address
Burial
Date thereof
(Burial, cremation, or removal: Which?)1-5-46
(month) (day) (year)
Fairview
Cemetery or cemeteryLocation
Covers Corner, Carroll Co. Md.18. Funeral director
C. M. WaltzAddress
Winfield, Md.19. Jan 4 1946
(Date rec'd by registrar)2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State
Maryland | County
CarrollCity or town
Mt. Olive
(If outside city or town limits, write RURAL and give nearest town)Street No.
R.D. Mt. Airy
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH
Jan. 3, 1946 at 12:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 28, 1945, to Jan. 3, 1946.

and that I last saw him alive on January 2, 1946.

Immediate cause of death.....

Cardiac decompensation
DURATION
6 weeksDue to.....
Ahs. Myocarditis
? yrs

Due to.....

Other conditions.....
Uremia
? yrs

(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

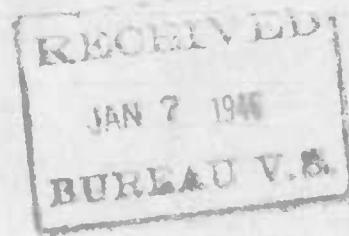
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....
Stanley Grubell
M. D. or otherAddress.....
Mt. Airy, Md. Date signed 1/3/46



PLEASE WRITE PLAINLY, WITH UNFADED INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

00396

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll

City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?

3. (a) FULL NAME

MARIE WARREN DORSEY

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	col.	divorced

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) July 30, 1911
.....(b.) If alive, give age years

8. AGE: Years	Months	Days	If less than one day
34	5	1hrs.min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

12. Name Charles Hammond

13. Birthplace Baltimore, Md.

14. Maiden name Fannie Dorsey

15. Birthplace Baltimore, Md.

16. Informant Reuben Hoffman, M.D.

Address Henryton, Maryland

17. Burial Burial
(Burial, cremation, or removal. Which?) Date thereof 1-7-46
(month) (day) (year)

Cemetery or crematory St Peter's Cemetery
Location Baltimore Md

18. Funeral director Mrs. Katie R. Williams
Address 322 1/2 Schreder Street

19. Jan. 1, 1946 Albert R. Smith
(Date rec'd by registrar) Deputy Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1213 Upton St.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

2D. DATE OF DEATH January 1, 1946 at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 3, 1945 to Jan. 1, 1946 and that I last saw her alive on Jan. 1, 1946.

Immediate cause of death Pulmonary Tuberculosis
DURATION Feb. 1937

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.
M. D. or other

Address Henryton, Md. Date signed 1-1-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

00397

Reg. Dist. No. 80

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County.....

Carroll

City or town.....

New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Walter Engel

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

6. (b) Name of husband or wife

Diana Albaugh

7. Birth date of deceased (mo., day, yr.)

Aug. 31 - 1866

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

79

4

3

hrs.

min.

9. Birthplace

(Town, county, and state)

Carroll County, Md

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

David Engel

13. Birthplace

Maryland

14. Maiden name

Matilda Fisher

15. Birthplace

Maryland

16. Informant

Walter Engel

Address

New Windsor, Md.

17. Burial

(Burial, cremation, or removal? Which?)

Date thereof

(month day year)

Cemetery or crematory

Piney Creek Cemetery

Location

Uptown Road

18. Funeral director

H. D. Hartley & Sons

Address

Elmwood

Elmwood

19. Date rec'd by registrar

1946

Date rec'd by registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town New Windsor

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 3 1946 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 1 1945 to January 3 1946

and that I last saw him alive on January 2 1946

Immediate cause of death

Hemiplegia

DURATION

2 days

Due to

Atherosclerotic C-1 disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

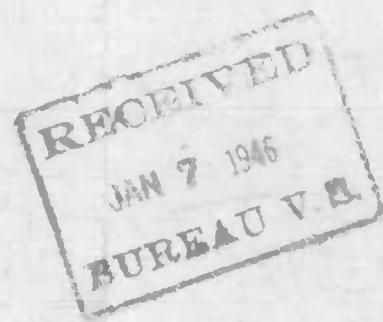
James T. March M.D.

M. D. or other

Address

Westminster Md

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

06398

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll

City or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

2 yrs. 8 mos., 22 days

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2329 Madison Ave., Apt. 4B

(If rural, give LOCATION)
World War I

2.(a) If veteran, name war

3. (a) FULL NAME

CLIFTON FIELDS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	Divorced

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) April 18, 1890

8. AGE: Years 55 Months 8 Days 23

It less than one day
.....hrs.min.

9. Birthplace Charlestown, West Virginia

(Town, county, and state)

Manager of Club

10. Usual occupation.....

11. Industry or business

MOTHER FATHER 12. Name John Fields

13. Birthplace Chambersburg, Pa.

MOTHER 14. Maiden name Evelyn Herbert

15. Birthplace Winchester, Va.

16. Informant Reuben Hoffman, M.D.

Address Henryton, Maryland

17. Burial Date thereof Jan. 15, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery

Location Baltimore, Md.

18. Funeral director Mrs. M. H. Holland

Address 1631 Laurel Hill Ave.

19. Jan. 11, 1946

(Date rec'd by registrar)

Albert R. Seaman

Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11, 1946 at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19, 1943, to Jan. 11, 1946, and that I last saw him alive on January 11, 1946.

Immediate cause of death Pulmonary Tuberculosis

DURATION
Jan. 1943

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

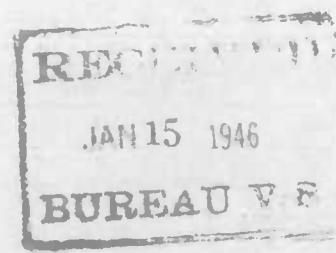
Means of injury..... Injured at work?

23. SIGNATURE Reuben Hoffman M.D.

M. D. or other

Address Henryton, Md.

Date signed 1-11-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

00390
42

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Carroll R.D. 1City or town Myers District, Westminster
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Herbert Henry Strock

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

8. (b) Name of husband or wife

Elizabeth (Crown) Strock6. (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.)

Dec. 20 - 1875

8. AGE:

Years

Months

Days

If less than one day

.

.

. hrs. min.

9. Birthplace

Carroll Co. Md.

(Town, county, and state)

10. Usual occupation

Farming

11. Industry or business

Farm

MOTHER FATHER

12. Name

John H. Strock

13. Birthplace

Carroll Co. Md.

14. Maiden name

Cornelia Morelock

15. Birthplace

Carroll Co. Md.

16. Informant

Hilda E. Strock

Address

Westminster, Md. R. D. 1

17. Burial

Date thereof Jan. 23 - 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Union Cemetery

Location

Silver Run, Md.

18. Funeral director

J. W. Little & Son

Address

Lylesboro, Pa. RURAL

19. Date rec'd by registrar

Jan. 21st 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

CarrollCity or town Westminster, R. D. 1
(If outside city or town limits, write RURAL and give nearest town)Street No. Myers District

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH Jan. 20 1946 at 10:20 A.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from as per 1945 to Jan. 20 1946 and that I last saw him alive on Jan. 20 1946Immediate cause of death Myocardial degeneration & Valvular Insufficiency, Edema
Due to Arteriosclerosis (General) + HypertensionDue to Prostatic Hypertrophy
Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

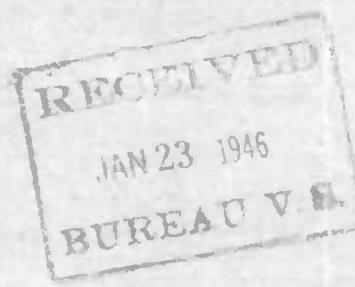
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 1/21/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17

CERTIFICATE OF DEATH

Reg. Dist. No. 0046934

1. PLACE OF DEATH:

Carroll
County.....
City or town..... Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 yrs. 1 mo. 4 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 16 yrs. 1 mo. 4 da.

3. (a) FULL NAME

SARAH GLOVER

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) February 2, 1869
8. (c) If alive, give age..... years

8. AGE: Years	Months	Days	It less than one day
76	10	30	hrs. min.

9. Birthplace.....
(Town, county, and state)

10. Usual occupation..... none

11. Industry or business..... none

12. Name..... Richard E. Glover

13. Birthplace..... Maryland

14. Maiden name..... Susan Conner

15. Birthplace..... Maryland

16. Informant..... Hospital Records

Address..... Sykesville Maryland

17. Burial..... Date thereof..... Jan. 12 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Springfield Hosp. Crem.

Location..... Sykesville, Md.

18. Funeral director..... C. Henry Ewer

Address..... Sykesville, Md.

19. Date rec'd by registrar..... Jan. 12 1946

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1301 Charles Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Januairy 8th 1946 at 7.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 4 18.29 to Jan. 8 1946

and that I last saw her alive on Jan. 8 1946

Immediate cause of death.....

General Arteriosclerosis

DURATION..... 16 yrs

Due to.....

Due to.....

Paranoid condition

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

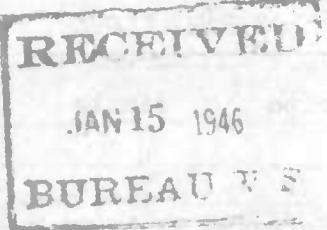
Injured at home, farm, Industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Maud M. Rees M.D.

M. D. or other

Address..... Sykesville Md. Date signed 1-8-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

CERTIFICATE OF DEATH

06481

74

Reg. Dist. No.

1. PLACE OF DEATH:

County

Carroll

City or town

rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yr., 6 mo., 12 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 2 yr., 6 mo., 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County

City or town

Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

1021 E. Biddle Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Grace Horth

3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Henry Horth

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 15, 1883

8. AGE:

Years Months Days If less than one day

62 1 07 hrs. min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

John Sybord

FATHER

12. Name

John Sybord

13. Birthplace

Md.

MOTHER

14. Maiden name

Pettigore

15. Birthplace

Md.

16. Informant

Springfield State Hospital records

Address

Sykesville, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Moreland Memorial Park

Location

Baltimore

18. Funeral director

William Cook, Jr.

Address

1217 St. Paul St.

19. (Date rec'd by registrar)

Jan. 23, 1946

E. Harry Drew

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 22, 1946, at 7:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1, 1943, to Jan. 22, 1946

and that I last saw her alive on Jan. 22, 1946

Immediate cause of death

Tuberous sclerosis

DURATION

4 yrs.

Due to

Due to

Other conditions

Psychosis with cerebral arteriosclerosis

4 yrs

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert C. Conrad, M.D.

M. D. or other

Address Sykesville, Md. Date signed 1-22-46

RECEIVED
JAN 24 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

00402

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 9 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?

3. (a) FULL NAME

HILDA HARPER

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female col. married

6. (b) Name of husband or wife Elijah Harper

7. Birth date of deceased (mo., day, yr.) April 28, 1920

6. (c) If alive, give age 27 years

8. AGE: Years Months Days If less than one day
25 8 13 hrs. min.9. Birthplace Bellhaven, N.C.
(Town, county, and state)

10. Usual occupation Waitress

11. Industry or business

12. Name Henry Windley

13. Birthplace North Carolina

14. Maiden name Emma Spencer

15. Birthplace Howard County, N.C.

16. Informant Reuben Hoffman, M.D.

Address Henryton, Md.

17. Burial

Date thereof Jan. 16, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sidney, N. Carolina

Location

A A Gaddis

18. Funeral director

Address 2101 McCullough St

Jan. 11, 1946

(Date rec'd by registrar)

Albert B. Sonnen

Deputy Local Registrar

Address

Henryton, Md.

Date signed

1-11-46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1204 McElderry Ct.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

220-14-1631

MEDICAL CERTIFICATION

2D. DATE OF DEATH Jan. 11, 1946 at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 2, 1945 to Jan. 11, 1946 and that I last saw her alive on Jan. 11, 1946

Immediate cause of death

Pulmonary Tuberculosis

DURATION

July 1945

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

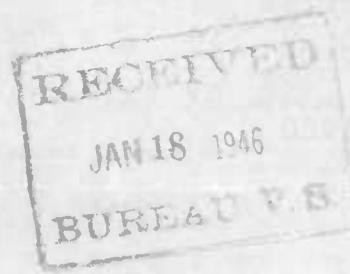
Reuben Hoffman, M.D.

M. D. or other

Address

Henryton, Md.

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20201

CERTIFICATE OF DEATH

00403

Reg. Dist. No. 24

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 3 mos 12 da

Hospital, institution, or street address where death occurred

Springfield State Hospital

How long in hospital or institution? 2 yrs 3 mos 12 da

3. (a) FULL NAME

Emma Florence Times

3. (b) Social Security Number

4. Sex

I

5. Color or race

W. Widowed

6. (a) Single, married, widowed, or divorced

B. (b) Name of husband or wife

William Stretzger

7. Birth date of

deceased (mo., day, yr.)

Oct 10 - 1871

8. (a) If alive, give age years

8. AGE:

Years 74 Months 2 Days 28 If less than one day hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name unknown

13. Birthplace

unknown

14. Maiden name

unknown

15. Birthplace

unknown

16. Informant

My Anna Stretzger

Address

Sharpsburg Md

17. (Burial, cremation, or removal) Which?

Burial Date thereof 15 1946

Cemetery or crematory

Sharpsburg Md

Location

Sharpsburg Md

18. Funeral director

Colish V. Hall

Address

Williamsport Md

19. Jan. 13 1946

C. Harry New

Date rec'd by registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md County Wash

City or town

Sharpsburg (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 12 th 1946 at 8:38 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 30 1943 to Jan 12 1946

and that I last saw her alive on Jan 12 th 1946

Immediate cause of death

Bronchitis Pneumonia 1 mth

Due to

Influenza 2 mth

Due to

asthma &clerosis 9

Other conditions

Hypertension

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

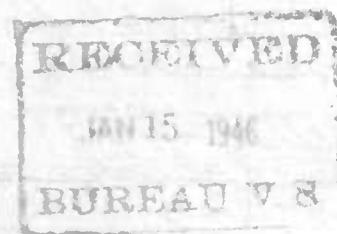
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Sharpsburg Date signed Jan 12 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Anna Christina Hoffman

3. (b) Social Security Number

7001

4. Sex

Female

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Horn

Hoffman

(6. c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 12 - 1862

8. AGE:

83

Years

2

Months

1

Days

If less than one day

hrs.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

MOTHER FATHER

Not Known

13. Birthplace

MOTHER

Not Known

14. Maiden name

15. Birthplace

Not Known

16. Informant

Mrs Russell Haines

Address

Westminster, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Jan 15 1946

Cemetery or crematory

Lister Cemetery

Location

Westminster, Md.

18. Funeral director

H Bankard & Son

Address

Westminster, Md.

19.

Date rec'd by registrar

1946

19

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

1-19-46

19

at 40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-12-1946 to 1-13-1946 1946

and that I last saw her alive on 1-13-46 19

Immediate cause of death

Breastoma of heart

DURATION

1 yr (0)

Due to

Due to

Other conditions

malnutrition 3 mos

3 mos

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

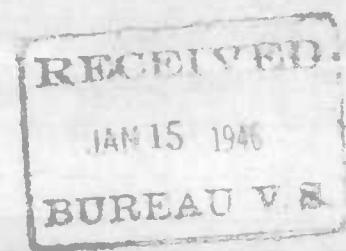
Injured at work?

23. SIGNATURE

W C Sloane

M. D. or other

Address Westminster Date signed 1-15-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48-6

00405

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/2 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mollie Hughes

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Charles W. Hughes

6. (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Aug. 28 - 1871

8. AGE: Years 24 Months 5 Days 6 If less than one day hrs. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Christopher Schell

13. Birthplace Md.

14. Maiden name Mollie known

15. Birthplace

16. Informant Mr. Albert Stone

Address Westminster, Md.

17. Burial Date thereof Jan 16-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Westminster Cemetery

Location Westminster, Md.

18. Funeral director H. B. Bankard & Sons

Address Westminster, Md.

19. Date record by registrar 1/14/46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7 Centre

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

Zone

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14, 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1945, to Jan. 14, 1946, and that I last saw her alive on Jan. 12, 1946.

Immediate cause of death

Cancer of uterus with extensive metastasis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Westminster, Md. Date signed 1/14/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

CERTIFICATE OF DEATH

00406 74
Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

14 days

How long in above place of death?
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?

3. (a) FULL NAME

WILLIAM HUNTER

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	col.	married

6. (b) Name of husband or wife Sarah Hunter
6. (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) May 16, 1906

8. AGE:	Years	Months	Days	If less than one day
	39	8	12	hrs. min.

9. Birthplace Greenville, N.C.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Thomas Hunter
13. Birthplace North Carolina

MOTHER 14. Maiden name Chelsa Harris
15. Birthplace Unknown

16. Informant Reuben Hoffman, M.D.
Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 31, 1946
(month) (day) (year)

Cemetery or crematory Greenville, N.C.

Location Greenville, N.C.

18. Funeral director Mrs. Adaline R. Williams
Address 322 97th Schroeder St.

19. Jan. 28, 1946 Albert R. Hoffman
(Date rec'd by registrar) Deputy Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore
City or town (If outside city or town limits, write RURAL and give nearest town)
Street No. 107 West York Street
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number
243-03-3663

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28, 1946 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 14, 1946, to Jan. 28, 1946, and that I last saw him alive on January 28, 1946.

Immediate cause of death Pulmonary Tuberculosis DURATION Oct. 1945

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

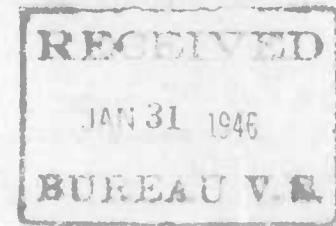
Injured at home, farm, Industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other

Address Henryton, Md. Date signed 1-28-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 751

CERTIFICATE OF DEATH

00467 74

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5501 Edmondson Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Elise Hutton

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 5. 17. 1857

8. AGE: Years 88 Months 8 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Montgomery County Md.
(Town, county, and state)

10. Usual occupation farming

11. Industry or business

MOTHER FATHER 12. Name Orlando Hutton
13. Birthplace Md.

MOTHER 14. Maiden name Sidney Buchanan
15. Birthplace Md.

16. Informant Cathrine Adams

Address Sandy Springs Md.

17. Removal Date thereof Jan 20 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bethesda

Location Location

18. Funeral director W. R. Pumphrey
Address Bethesda Md.

19. Date Jan 20 1946 C. Elise Hutton
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20, 1946 at 12.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 8, 1946 to Jan. 20, 1946
and that I last saw h. Jan. 20, 1946

Immediate cause of death chronic myocarditis DURATION
with myodegeneration years

Due to arteriosclerosis

Due to.....

Other conditions psychosis

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

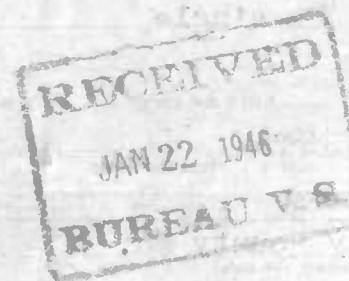
Means of injury..... Injured at work?

23. SIGNATURE The Plaintiff M. D. or other Springfield State Hosp.

Date signed 1-20-46

RECEIVED BY THE UNITED STATES GOVERNMENT

STAMP TO BE ATTACHED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

06408

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll

City or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 months, 10 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?

3. (a) FULL NAME

LUTHER JENKINS

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	col.	single

B.(b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 11, 1931

8. AGE: Years	Months	Days	If less than one day
14	3	27	hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Scholar

11. Industry or business

12. Name Alonzo Jenkins13. Birthplace Greenville, N.C.14. Maiden name Elizabeth Alford15. Birthplace Bennettsville, S.C.16. Informant Reuben Hoffman, M.D.Address Henryton, Maryland17. Burial Burial Date thereof 1-13-46
(Burial, cremation, or removal. Which?) Date (month) (day) (year)Cemetery or crematory Mt. Calvary CemeteryLocation 18. Funeral director Mrs. Robt. ElliottAddress 1129 N. Caroline St. Balt.

19. Jan. 8, 46 (Date rec'd by registrar)

Jan. 8, 46 (Date of death)

Jan. 8, 46 (Date signed)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

Maryland

State Maryland County BaltimoreCity or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 217 Beale Court

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH January 8, 1946 at 3:00 A.M.2L I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 28, 1945 to Jan. 8, 1946and that I last saw him alive on Jan. 8, 1946Immediate cause of death Tuberculous Meningitis DURATION Dec. 25 1945Due to Pulmonary Tuberculosis Jan. 1939

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

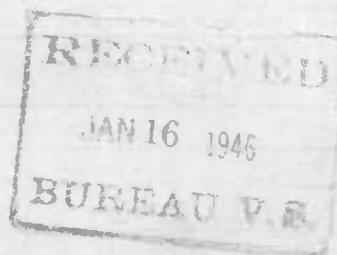
Means of injury

Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.

M. D. or other

Address Henryton, Md.Date signed 1-8-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age, is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

CERTIFICATE OF DEATH

00469

Reg. Dist. No. 72

1. PLACE OF DEATH:

County Carroll
City or town Rose Waterside
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life
Hospital, Institution, or street address where death occurred: Union Mills

How long in hospital or institution?

3. (a) FULL NAME

Norman E. Keeney

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) August 20 - 1945

8. AGE: Years 5 Months 9 Days 9 If less than one day
hrs. min.

9. Birthplace Towson - Md
(Town, county, and state)

10. Usual occupation Teacher

11. Industry or business None

12. Name Norman E. Keeney

13. Birthplace Waccamsville - Md

14. Maiden name Flowers Marjanna Waters

15. Birthplace Marston

16. Informant Norman E. Keeney

Address Waccamsville - Md. House

17. Burial Burial Date thereof Aug 30 - 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Methodist Cemetery

Location Towsonville Maryland

18. Funeral director Dr. D. Hatch & Sons

Address Union Bridge & New Windsor Rd

19. Date rec'd by registrar Jan 29th, 1946 Calvin Baskett
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Carroll
City or town Rose Waterside
(If outside city or town limits, write RURAL and give nearest town)
Street No. Union Mills
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19..... to 19.....

and that I last saw him..... alive on 19.....

Immediate cause of death

PneumoniaNo autopsy was done. Kind of postmortemDue to Unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

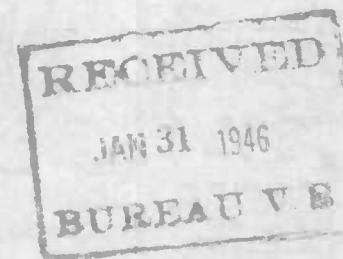
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James A. Mohr Deputy Medical Examiner
M. D. or otherAddress Waccamsville - Md Date signed 1/29/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

CERTIFICATE OF DEATH

00410

Reg. Dist. No. 24

1. PLACE OF DEATH:

County Carroll

City or town Sykesville, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months 18 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 2 months 18 days

3. (a) FULL NAME

Merle Vincent King

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Lucy King

6. (c) If alive, give age 18 years

7. Birth date of deceased (mo., day, yr.)

February 16, 1925

8. AGE:

Years 20

Months 10

Days 27

If less than one day

hrs.

min.

9. Birthplace

Clarksville, Md

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name Walden V. King

13. Birthplace Clarksville, Md

14. Maiden name Sera Shingley

15. Birthplace Maryland

16. Informant Lucy King (wife)

Address Clarksville, Md

17. Burial Date thereof Jan 14 1946

(Burial, cremation, or removal? Which?) (month) (day) (year)

Cemetery or crematory Clarksville, Md

Location Montgomery Co. Md

18. Funeral director Brown Barber

Address Catonsville, Md

19. Date rec'd by registrar Dec 13, 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Montgomery

City or town Clarksville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12, 1946, at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 25, 1945, to January 12, 1946,

and that I last saw him alive on January 11, 1946.

Immediate cause of death

Chronic myocarditis

DURATION

?

Due to Rheumatic heart disease

Edema of brain

?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE M. Virginia Beyer, M.D.

M.D. or other

Address Sykesville, Md

Date signed Jan 12, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

06411

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 3 days

3. (a) FULL NAME

Nellie Czischeck Knodle

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6. (b) Name of husband or wife Clifton Knodle

7. Birth date of deceased (mo., day, yr.) 9/20/1873
6. (c) If alive, give age years

8. AGE: Years	Months	Days	If less than one day
72	4	8	hrs. min.

9. Birthplace Cincinnati, Ohio
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
12. Name Oscar Czischeck
13. Birthplace Germany

MOTHER
14. Maiden name Elizabeth Brune
15. Birthplace Germany

16. Informant Clifton Knodle

Address 415 N. Franklin St.
Hagerstown, Md. Date thereof Jan. 28, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Hagerstown, Md.

18. Funeral director C. M. Glavin & Sons

Address Hagerstown, Md.

19. Date rec'd by registrar Jan. 28, 1946 C. Harry Shee
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 415 N. Franklin Street
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1946 at 2:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/25/1946 to 1/28/1946 and that I last saw her alive on Jan. 28 1946.

Immediate cause of death

Chronic Myocarditis

Due to Generalized Arteritis

Due to

Other conditions Psychosis due to Circulatory Changes unknown
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

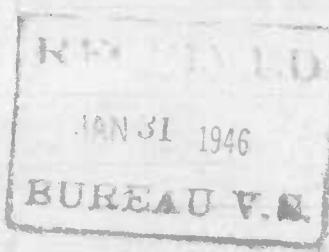
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arnold H. Eichet, M.D. M. D. or other

Address S. S. Hosp. Sykesville, Md. Date signed 1-28-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-8

66412

P.

74

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Carroll

City or town..... rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 5 months, 2 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution?..... 5 months, 2 days

3. (a) FULL NAME

Czeslaw S. Korzeniewski

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced

male..... white..... married

6. (b) Name of husband or wife..... Stefania

7. Birth date of deceased (mo., day, yr.)..... Unknown
6. (c) If alive, give age..... 48 years8. AGE: Years..... Months..... Days..... If less than one day.....
60 (?)..... hrs. min.9. Birthplace..... Poland (Suwalski)
(Town, county, and state)

10. Usual occupation..... Watchmaker

11. Industry or business

12. Name..... Stanislaus Korzeniewski

13. Birthplace..... Poland

14. Maiden name..... Unknown

15. Birthplace..... Poland

16. Informant..... Springfield State Hosp. records
Address..... Sykesville, Maryland17. Burial..... Date thereof..... 1/7/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Holy Rosary

Location..... German Hill Road

18. Funeral director..... M. J. Sadowski

Address..... 1808 Eastern Avenue,

19. Date rec'd by registrar..... 1-5 1946
(Date rec'd by registrar) A. W. Gedney
Registrar
dk

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore City
(If outside city or town limits, write RURAL and give nearest town)Street No..... 1732 Fleet Street
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 4 1946 11:10a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 21 1945 to Jan. 4 1946

and that I last saw him alive on January 4 1946

Immediate cause of death.....

Cerebral thrombosis

DURATION

24 hrs.

Due to..... Arteriosclerosis, prior to 1944

Due to.....

Other conditions..... Psychosis with cerebral arteriosclerosis
(Include pregnancy within 8 months of death)

1 year

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury.....

Injured at work?..... Robert Bertrand May, M.D.

23. SIGNATURE..... Robert Bertrand May, M.D.

Springfield State Hospital M. D. or brother

Address..... Sykesville, Maryland Date signed..... 1-4-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

00413

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

Carroll
County.....rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yr., 2 mo., 18 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 8 yr., 2 mo., 18 days

3. (a) FULL NAME

Frederick Kothe

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced
male white single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) June 12, 1851
6. (c) If alive, give age..... years8. AGE: Years Months Days If less than one day
94 6 24 hrs. min.9. Birthplace..... Baltimore City, Maryland
(Town, county, and state)

10. Usual occupation..... laborer

11. Industry or business..... agriculture

12. Name..... George Kothe

13. Birthplace..... Germany

14. Maiden name..... Catherine Bentz

15. Birthplace..... Germany

16. Informant..... Springfield State Hosp. records
Address..... Sykesville, Maryland17. Burial..... Date thereof..... Jan. 6, 1946
(Burial, cremation, or removal? Which?) (month) (day) (year)

Cemetery or crematory..... Loudon Park Cem.

Location..... Balt. Md.

18. Funeral director..... William Cook, Inc.
Address..... 1217 St. Paul St.19. Date rec'd by registrar..... Jan. 6, 1946
(Date rec'd by registrar) C. Harry Wees
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore City
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 6, 1946, at 11:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 1, 1943, to Jan. 6, 1946,
and that I last saw him alive on January 6, 1946.

Immediate cause of death.....

Senility

DURATION

28 yrs.

Due to..... Arteriosclerosis

28 yrs.

Due to.....

Other conditions..... Senile psychosis.

28 yrs.

simple deterioration

(Include pregnancy within 3 months of death)

28 yrs.

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

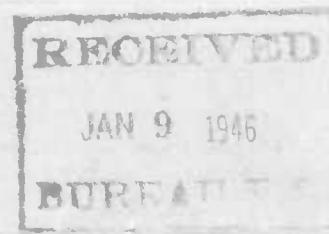
Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE..... Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address..... Sykesville, Maryland Date signed..... 1-6-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

06414

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred.

Springfield State Hospital

How long in hospital or institution?

4 yrs 2 mos 15 da

3. (a) FULL NAME

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

B. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

March 27 - 1875

6. (c) If alive, give age.....

years

8. AGE: Years

70

Months

9

Days

15

If less than one day

hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

12. Name.....

Frank Deury

13. Birthplace

Pa

14. Maiden name.....

Laura Calomer

15. Birthplace

Pa

16. Informant.....

Miss Myrtle Deury

Address

Waynesboro Pa

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof.....

(month) (day) (year)

Cemetery or crematory

Maurine

Location

Maurine

18. Funeral director.....

Walter J. Gore

Address

27 South Church St Waynesboro Pa

19. (Date rec'd by registrar)

Jan. 12 1946

(Date rec'd by registrar)

C. Henry Weller

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.....

Md

County.....

Wash Co

City or town.....

Hagerstown

Street No.....

J

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Jan 12th 1946, at 5-20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 27 1945 to Jan 12 1946

and that I last saw her alive on Jan 12th 1946

Immediate cause of death.....

Coronary thrombosis

Duration.....

Hours

Due to.....

Asteno Sclerotic

Hypertension

Duration.....

9

Due to.....

Asteno Sclerotic

Hypertension

Duration.....

(Include pregnancy within 3 months of death)

Other conditions.....

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

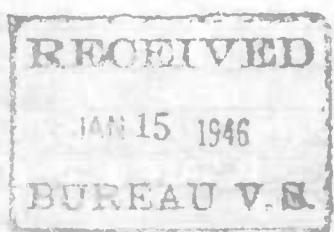
Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Date signed.....

Signature..... M. D. or other

Address..... Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 480

00415

CERTIFICATE OF DEATH

Reg. Dist. No. 72

1. PLACE OF DEATH:

County Carroll

City or town Westminster, R.D. 1, Silver Run.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Emma Kate Lawyer

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife

Era M. Lawyer

7. Birth date of deceased (mo., day, yr.)

Nov. 9. 1862

8. (c) If alive, give age Dead years

8. AGE:

Years

Months

Days

If less than one day

83

2

5

hrs. min.

9. Birthplace

Carroll Co. Md.

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Home

MOTHER FATHER

Name

Teri Singling

MOTHER FATHER

Name

Carroll Co. Md.

MOTHER FATHER

Name

Catherine Hribling

MOTHER FATHER

Name

Carroll Co. Md.

16. Informant

Emma Lawyer

Address

Westminster, Md. R.D. 1

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Jan. 17-1946

(month) (day) (year)

Cemetery or crematory

Union Cemetery

Location

Silver Run. Md.

18. Funeral director

G. M. Little & Son

Address

Littlestown, PA. Reg. P.A.L.

19. Jan. 15th 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster, R.D. 1, Silver Run.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan. 14 1946 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 1 1945 to Jan. 14 1946

and that I last saw her alive on Jan. 9 1946

Immediate cause of death

Cancer of uterus
with extensive metastasis

DURATION

4 yrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Westminster Date signed 1-15-46



UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	RECEIVED
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

00417

Reg. Dist. No. 74

1. PLACE OF DEATH:

Carroll

County

Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 7 mo. 28 da.

Hospital, institution, or street address where deceased:

Springfield State Hospital

How long in hospital or institution? 1 yr. 7 mo. 28 da.

3. (a) FULL NAME

EDITH MILNOVSKY

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	married

6. (b) Name of husband or wife Joseph Milnovsky

7. Birth date of deceased (mo., day, yr.) October (unknown) 1894

8. AGE: Years	Months	Days	If less than one day
51	3		hrs. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business home

12. Name Elias Liberatsky

13. Birthplace Poland

14. Maiden name Ruth Felsman

15. Birthplace Poland

16. Informant Hospital Records

Address Sykesville, Maryland.

17. Burial Date thereof 1-14-46

(Burial, cremation or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Carmel

Location Germany Hell Kat

18. Funeral director Jack Lewis Lee

Address 1439 E. Ball St

19. Jan. 13 1946 C. Harry Weir

(Date rec'd by registrar) (Signature) (Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3 North Collington Avenue

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH January 13 1946 a.m. 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 4, 1944, to Jan. 13, 1946

and that I last saw h. w. alive on January 13, 1946

Immediate cause of death

Coronary Thrombosis

Due to

Due to

Other conditions

Schizophrenia--catatonic type 2 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

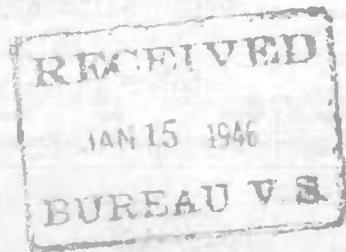
Means of injury

Injured at work?

23. SIGNATURE Maud M. Rea M.D. M. D. or other

Address Sykesville, Md. Date signed 1-13-46

RECEIVED BY THE UNITED STATES GOVERNMENT
RECORDED BY AUTOMATIC



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

06418
Reg. Dist. No. 94

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
County Carroll

City or town Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos. 8 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 2 months 8 days

3. (a) FULL NAME

Caroline G. Morris

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Thomas Morris

7. Birth date of deceased (mo., day, yr.) April 14, 1861
6. (c) If alive, give age years

8. AGE: Years 84 Months 10 Days 7 If less than one day hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
12. Name Edward Kosack
13. Birthplace Germany

14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Records of Springfield State Hospital
Address Sykesville, Md.

17. Removal Date thereof 1-21-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory
Location Bethesda, Md.

18. Funeral director Wm. Remond Murphy
Address Bethesda, Maryland

19. Jan. 21 1946 C. Henry Weller
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 19 46, at 8:55 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/13/ 19 45, to 1/21/ 19 46, and that I last saw her alive on January 21 19 46.

Immediate cause of death

Pneumonia (terminal) DURATION 2 days

Due to

Due to

Other conditions Female, 80 yrs., single
terminal (Include pregnancy within 3 months of death) 6 years

Major findings of operations

Date of op.

Ante mortem results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

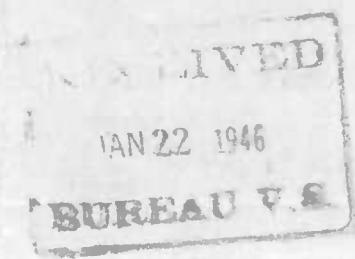
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Arnold H. Eichet M.D.

Springfield State Hospital ^{MD} _{or other}
Address Sykesville, Maryland Date signed 1/21/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

00419

Reg. Dist. No. 88

1. PLACE OF DEATH:

County.....

Carroll

City or town.....

New Windsor, md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Flora Alice Myers

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female white single

6. (b) Name of husband or wife.....

7. Birth date of
deceased (mo., day, yr.)

Jan 15 - 1863

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

82 11 24

hrs.

min.

9. Birthplace.....

Maryland

(Town, county, and state)

10. Usual occupation.....

Practical

11. Industry or business

nurse

12. Name.....

Jesse Myers

13. Birthplace.....

Maryland

14. Maiden name.....

Mary Catherine Myers

15. Birthplace.....

Maryland

16. Informant.....

Edna Wilson

Address

New Windsor, md

17. Burial.....

Date thereof (month) (day) (year)

(Burial, cremation, or removal. Which?)

Winter's Cemetery

Cemetery or crematory.....

New Windsor, R.D.

Location.....

D.D. Hartley & Sons

18. Funeral director.....

Union Bridge & New Windsor, md

Address

James 10 1946

19. (Date rec'd by registrar)

Ericie E. Bondur

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Carroll

City or town.....

New Windsor, md

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 8 1946 at 7:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1945 to January 8 1946

and that I last saw her alive on

Immediate cause of death.....

Generalized arteritis sicca

DURATION

years

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

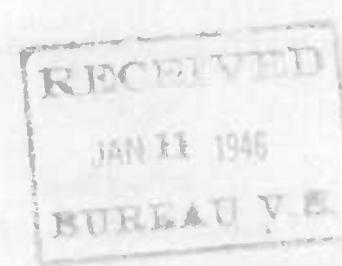
Address

James 9 March 1946

M. D. or other

Address

Date signed Jan 8 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

00420

Reg. Dist. No. 72

1. PLACE OF DEATH:

County CarrollCity or town Westminster, P.D. 2, Union Mills
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? _____

3. (a) FULL NAME

Herbert Terminus Myers

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married6. (b) Name of husband or wife Sarah (Gamer) Myers

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age 73 years7. Birth date of deceased (mo., day, yr.) July 20 - 18768. AGE: Years 69 Months 5 Days 22 If less than one day

hrs. _____ min. _____

9. Birthplace Carroll County, Md.
(Town, county, and state)10. Usual occupation Saw Mill operator11. Industry or business Saw Mill12. Name Terminus Myers13. Birthplace Carroll County, Md.14. Maiden name Alberta Baskert15. Birthplace Carroll County, Md.16. Informant Mrs Herbert J. MyersAddress Westminster, Md P.D. 217. Burial Burial Date thereof Jan. 15-1946
(Burial, cremation, or removal. Which?)Cemetery or crematory Methodist CemeteryLocation Union Mills, Md.18. Funeral director J. W. Little & SonAddress Littlestown, PA. Per P.A.L.19. Date rec'd by registrar Jan. 12, 1946 Calvin E. Knott
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarrollCity or town Westminster, P.D. 2, Union Mills
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

213-18-8468

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12 1946 at 7 A.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1st 1945 to Jan 12 1946and that I last saw him alive on Jan 12 1946Immediate cause of death Cancer of Liver

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

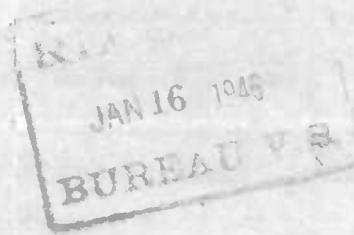
Means of injury _____

Injured at work? _____

23. SIGNATURE John J. Stewart

M. D. or other

Address Westminster, Md. Date signed Jan 12, 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

00421

740

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 2

3. (a) FULL NAME

Joseph PATRO

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

6. (b) Name of husband or wife

Frances Rachuba -

7. Birth date of deceased (mo., day, yr.)

1891

6. (c) If alive, give age years

8. AGE:

55

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Warsaw - Poland

(Town, county, and state)

10. Usual occupation

Baker

11. Industry or business

Kahlman & Lanson (Bakers)

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Michael M. Patro

Address

2101 E. Federal Street

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 1/15/46
(month) (day) (year)

Cemetery or crematory

St. Stanislaus

Location

Tundale Ave.

18. Funeral director

John J. Connally

Address

418 Eastern Ave. Etsey 21

19. Date rec'd by registrar

1-14 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 257 N. Exeter Street

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 10 1946, at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 8 1946, to January 10 1946, and that I last saw him alive on January 10 1946.

Immediate cause of death

Pulmonary tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Arnold H. E. Hart, M.D.

M. D. or other

Address

1109, Sykesville, Md.

Date signed

1-11-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

00422

Reg. Dist. No.

78

1. PLACE OF DEATH: Carroll
 County.....
 City or town..... Mt. Olive
 (If outside city or town limits, write RURAL and give nearest town) 34 years
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:.....
 How long in hospital or institution?.....

3. (a) FULL NAME
 Curtis Singler Penn
 4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced
 Male White Married
 Emily Ruth Penn

6. (b) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.)..... April 1, 1878
 8. (c) If alive, give age..... 61 years

8. AGE: Years..... 67 Months..... 9 Days..... 17 If less than one day.....
 hrs. min.

9. Birthplace..... Carroll Co. Maryland
 (Town, county, and state)

10. Usual occupation..... Farmer

11. Industry or business.....
 12. Name..... Milton H. Penn
 13. Birthplace..... Maryland

MOTHER FATHER
 14. Maiden name..... Mary K. Grimes
 15. Birthplace..... Maryland

16. Informant..... Mrs. Emily R. Penn
 Address..... Mt. Airy, Md.

17. Burial..... Date thereof..... 1-21-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Bethel Church of God

Location..... nr. Winfield, Carroll Co. Md.

18. Funeral director..... C. M. Waltz
 Address..... Winfield, Md.

19. Date rec'd by registrar..... 1-20-46
 (Date rec'd by registrar) 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Carroll
 City or town..... Mt. Olive
 (If outside city or town limits, write RURAL and give nearest town) Rural--Mt. Airy
 Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan. 1, 8 1946, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....

and that I last saw h..... alive on 19.....

Immediate cause of death..... 4

.....
 Due to.....

 Due to.....

 Due to.....

Other conditions.....

 (Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

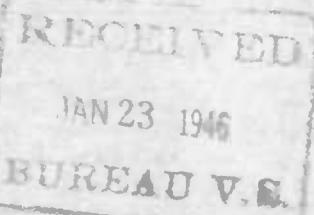
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... James & Charles Deputy Physician Examiner

M. D. or other..... M.D. or other.....

Address..... Westminster, Md. Date signed..... 1-8-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

00423

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
Carroll
County

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs. 6 mo. 29 da.

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 5 yrs. 6 mo. 29 da.

3. (a) FULL NAME

JANE BLANCHE PERRY

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	married

6. (b) Name of husband or wife
William Perry
unknown

7. Birth date of deceased (mo., day, yr.) December 30, 1883

8. AGE: Years	Months	Days	If less than one day
62	0	16	hrs. min.

9. Birthplace Canada
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business home

FATHER 12. Name George B. Kingston

MOTHER 13. Birthplace Canada

14. Maiden name Ellen Mc. Clean

15. Birthplace Canada

16. Informant Hospital Records

Address Sykesville, Maryland.

17. Burial Date thereof Jan. 19, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Cross Cem.

Location A. C. Co., Md.

18. Funeral director Charles A. Dill

Address E. Fort Ave Baltimore

19. Jan. 16 1946 C. Harry Weir
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1442 Hull Street
(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15th. 1946, at 11.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 27, 1944, to Jan. 15 1946

and that I last saw her alive on Jan. 15th 1946

Immediate cause of death carcinoma of the head of pancreas with metastases to the liver

DURATION

over
1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

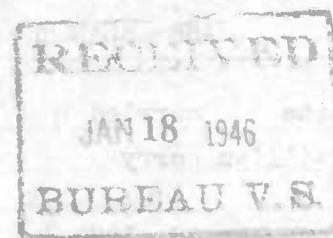
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Mabel M. Race M.D.

M. D. or other

Address Sykesville, Md. Date signed Jan 15 1946



Evidence for change of
birth date of deceased is

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 982

06424

FILM No. 100 JAN 18 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Clara Elizabeth Pittenger

3. (b) Social Security Number

7001

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

William Pittenger

7. Birth date of

deceased (mo., day, yr.)

August 10 - 1857

6. (c) If alive, give age years

8. AGE:

Years

88

Months

5

Days

2

If less than one day

hrs. min.

9. Birthplace

Unionville, Fred. Co. Md.

(Town, county, and state)

10. Usual occupation

7001

11. Industry or business

MOTHER FATHER

Martie Pickens

13. Birthplace

Fred. Co. Md.

MOTHER

Lucinda Cartis

15. Birthplace

Frederick, Md.

16. Informant

J. R. Sheets

Address

103 W. Green St. Westminster, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Jan. 15-1946

(month) (day) (year)

Cemetery or crematory

Linganore Cemetery

Location

Unionville, Fred. Co. Md.

18. Funeral director

H. Barkard & Sons

Address

Westminster, Md.

19. (Date record by registrar)

1/14 1946 Greenwood

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarrollCity or town Westminster (If outside city or town limits, write RURAL and give nearest town)Street No. 103 W. Green

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 12 1946 at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 14-1945 to Jan 12 1946and that I last saw her alive on Jan 12 1946Immediate cause of death arterio-sclerotic DURATION(General) myocardialdegeneration + valvularinsufficiencyScrupulously

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

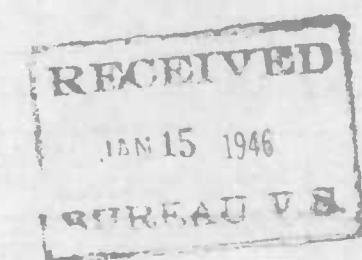
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Westminster, Md. Date signed 1/12/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-3

06425

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH: Carroll
 County
 City or town Rural--Mt. Airy
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 51 years
 Hospital, institution, or street address where death occurred:
 Now long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

Maryland County Carroll
 City or town Rural--Mt. Airy
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.D. Mt. Airy
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

MINNIE ELLSWORTH POOLE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B.(b) Name of husband ~~Samuel C. Poole~~
 deceased

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1861

8. AGE: Years 84 Months 0 Days 22 It less than one day hrs. min.

9. Birthplace Howard Co. Maryland

9. Birthplace (Town, county, and state) None

10. Usual occupation.....

11. Industry or business Milton L. Becroft

12. Name..... Maryland

13. Birthplace Rebecca Watkins

14. Maiden name..... Maryland

15. Birthplace Mrs. Francis Hunter

16. Informant..... Mt. Airy, Md.

Address..... Burial 1-4-46

17. (Burial, cremation, or removal: Which?) Date thereof..... (month) (day) (year)
 Mt. Olive

Cemetery or crematory..... Mt. Olive, Carroll Co. Md.

Location..... C. M. Waltz

18. Funeral director..... Winfield, Md.

Address.....

19. 1-3-46 (Date rec'd by registrar) 1946

S. M. Poole
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1, 1946 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 22, 1945, to Jan. 1, 1946

and that I last saw her alive on Jan. 1, 1946

Immediate cause of death Labor & Pneumonia

DURATION 4 days

Due to La grippe and general debility due to age

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

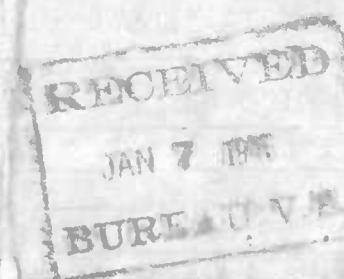
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Date signed 1-3-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-6

00426

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
Carroll
County
City or town. Henryton
(If outside city or town limits, write RURAL and give nearest town)
2 months, 6 days
How long in above place of death?
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
Maryland County
State. Maryland County. Prince George's
City or town. Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME

LULA POWELL

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced
female col. widowed

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 6.(c) If alive, give age..... years
January 15, 1893

8. AGE: Years Months Days If less than one day
53 0 10 hrs. min.

9. Birthplace..... Anne Arundel County
(Town, county, and state)

10. Usual occupation..... Domestic

11. Industry or business.....

FATHER 12. Name..... Frank Powell
Anne Arundel County

MOTHER 13. Birthplace..... Anne Arundel County

MOTHER 14. Maiden name..... Rachel Junior
Anne Arundel County

15. Birthplace..... Anne Arundel County

16. Informant..... Reuben Hoffman, M.D.
Address..... Henryton, Maryland

17. Date of death..... 1/28/46
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Mt. Zion

Location..... Laurel, Md.

18. Funeral director..... Katie B. Wilson

Address..... 322 N. Shoulder St.

19. Date rec'd by registrar..... Jan. 25, 1946

Deputy Local Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 25, 1946, at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 19, 1945, to Jan. 25, 1946,

and that I last saw her alive on January 25, 1946.

Immediate cause of death..... Pulmonary Tuberculosis

DURATION
April 1945

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

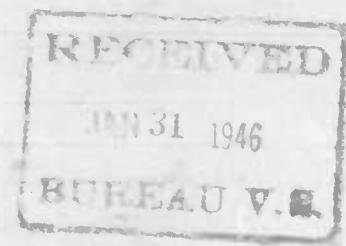
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Reuben Hoffman, M.D. M. D. or other

Address..... Henryton, Md. Date signed 1-25-46

(Date rec'd by registrar)



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

00427

74

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 4 mos., 6 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town 1006 N. Bond Street
(If outside city or town limits, write RURAL and give nearest town)
Street No. Baltimore, Md.
(If rural, give LOCATION) ✓

3. (a) FULL NAME

FLORINE IDEL PRESTON

3. (b) Social Security Number

220-18-6379

4. Sex female 5. Color or race Col. 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 6, 1925 6.(c) If alive, give age years

8. AGE: Years 20 Months 10 Days 15 If less than one day hrs. min.

9. Birthplace Lynchburg, Va. (Town, county, and state)

10. Usual occupation Waitress

11. Industry or business

MOTHER FATHER 12. Name Robert Preston
13. Birthplace Prospect, Va.

14. Maiden name Janie ?
15. Birthplace Unknown

16. Informant Reuben Hoffman, M.D.
Address Henryton, Maryland

Burial Cemetery or crematory Date thereof Jan. 26, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lynchburg, Va.
Location Campbell Cemetery

18. Funeral director Mrs. Lotte' Glass
Address 1408 Ashland Ave Baltimore

Jan. 21, 1946 Alastair P. Swindham
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21, 1946 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15, 1944 to Jan. 21, 1946 and that I last saw her alive on Jan. 21, 1946.

Immediate cause of death Tuberculosis of the Spine DURATION June 6, 1944

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings or operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

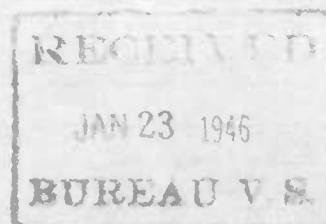
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other

Address Henryton, Md. Date signed 1-21-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

00428

CERTIFICATE OF DEATH

74
Reg. Dist. No.

1. PLACE OF DEATH:

Carroll

County

Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 3 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?

3. (a) FULL NAME

WILLIAM PRICE

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

col.

married

B. (b) Name of husband or wife

Pauline Price

7. Birth date of
deceased (mo., day, yr.)

January 5, 1917

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Scotland Neck, N.C.

(Town, county, and state)

10. Usual occupation

Sprayer in defense plant

11. Industry or business

John Price

FATHER

12. Name

Scotland Neck, N.C.

MOTHER

13. Birthplace

May Jacobs

14. Maiden name

Scotland Neck, N.C.

15. Birthplace

Reuben Hoffman, M.D.

16. Informant

Henryton, Maryland

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 1-10-46

(month) (day) (year)

Cemetery or crematory

Mt Calvary

Location

A. C.

18. Funeral director

Elroy O. Wilson

Address

1000 Mantley Ave

19. Jan. 7, 1946

(Date rec'd by registrar)

Allan R. Seawall

Deputy Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

State County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 420 N. Eden Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

237-14-5485

MEDICAL CERTIFICATION

2D. DATE OF DEATH January 7, 1946, 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 4, 1945, to Jan. 7, 1946

and that I last saw him alive on Jan. 7, 1946

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Aug.

1945

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

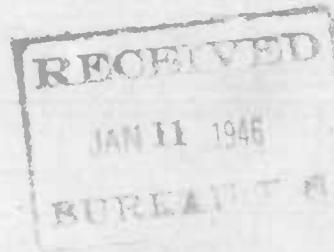
23. SIGNATURE

Reuben Hoffman, M.D.

M. D. or other

Address Henryton, Md.

Date signed 1-7-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 00429

1. PLACE OF DEATH: Carroll
 County.....
 City or town..... rural near Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 16 yr., 8 mo., 10 days
 Hospital, Institution, or street address where death occurred: Springfield State Hospital
 How long in hospital or institution? 16 yr., 8 mo., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... Maryland County.....
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION) ✓

2.(a) If veteran, name war.....

3. (a) FULL NAME

Harry J. Reinfelder

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) June 29, 1912
 (c) If alive, give age years

8. AGE: Years	Months	Days	If less than one day
33	6	12	hrs. min.

9. Birthplace..... Baltimore, Maryland
 (Town, county, and state)

10. Usual occupation..... none

11. Industry or business.....

12. Name..... George Reinfelder

13. Birthplace..... Baltimore, Maryland

14. Maiden name..... Minnie H. Rohrman

15. Birthplace..... Baltimore, Maryland

16. Informant..... Springfield State Hosp. records
 Address..... Sykesville, Maryland17. Burial..... Burial (Burial, cremation, or removal. Which?)
 Date thereof..... 1-15-45
 (month) (day) (year)

Cemetery or crematory..... Belts Pem

Location..... North Ave

18. Funeral director..... Muller Inc

Address..... 2435 E Oliver St

19. (Date recd by registrar) 11/2/46 19. 46

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 11 19. 46, at 3:40p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19. 43, to Jan 11 19. 46

and that I last saw him alive on January 11 19. 46

Immediate cause of death..... Chronic myocarditis and myocardial degeneration, prior to Jan '46

Due to.....

Due to.....

Other conditions..... Dementia precox, hebephrenic type
 (Include pregnancy within 3 months of death) 18 yrs.

Major findings of operations.....

Autopsy results..... Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE..... Springfield State Hospital M. D. or other

Address..... Sykesville, Maryland Date signed 1-11-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

00430

81.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County CarrollCity or town Middleburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Eighteen

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Jesse Reisler

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

Mary Reisler

6. (b) Name of husband or wife

B. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

October 8 - 1855

8. AGE:

Years

Months

Days

If less than one day

90

9

29

hrs. min.

9. Birthplace

Frederick Co Maryland

(Town, county, and state)

10. Usual occupation

Hotel Proprietor

11. Industry or business

Retired

MOTHER FATHER

12. Name

Thomas Reisler

13. Birthplace

Maryland

14. Maiden name

Margaret Smith

15. Birthplace

MarylandGrace Lynn

16. Informant

Address

Middleburg Maryland

17. Burial

Date thereof Jan. 10 - 1946

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Mountain View Cemetery

Location

Union Bridge Maryland

18. Funeral director

D. D. Shaffer & Son

Address

Union Bridge & New Windsor Rd19. Jan. 8 1946

(Date rec'd by registrar)

P. Richardson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarrollCity or town Middleburg (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 7 1946 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 6 1946 to Jan. 7 1946 and that I last saw him alive on Jan. 6 1946

Immediate cause of death

Heart Failure

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

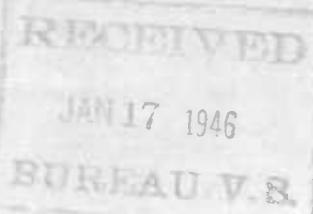
23. SIGNATURE

J. H. Meekin M.D.

M. D. or other

Address

Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

00431

CERTIFICATE OF DEATH

Reg. Date. No. 24

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs 4 mos 26 da

Hospital, institution, or street address where death occurred:

Springfield State Hospital

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

41

18

2

hrs.

min.

9. Birthplace.....

(Town, County, and state)

Russia

10. Usual occupation.....

Housework

11. Industry or business.....

At home

MOTHER FATHER

12. Name.....

Joseph Rosenberg

13. Birthplace.....

Russia

14. Maiden name.....

Sofia Palansky

15. Birthplace.....

Russia

16. Informant.....

Mrs Elizabeth Lurland

Address.....

1347 Reisterstown Rd Baltimore

17. Burial.....

Burial Date thereof..... 18. 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Belvoir Rosedale

Location.....

Bald. rd.

18. Funeral director.....

Jackie Lewis

Address.....

2100 Eastern Ave

19. Date rec'd by registrar.....

Jan. 17 1946

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 16th 1946 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 21st 1940 to Jan 9th 1946

and that I last saw her alive on Jan 16th 1946

Immediate cause of death.....

Broncho Pneumonia 2wk

Due to.....

Influenza 2wk

Due to.....

Huntington's Chorea 10 yrs

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

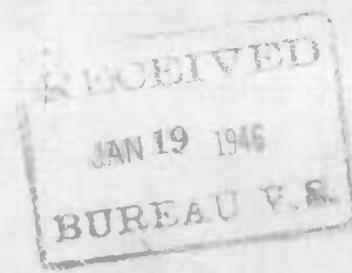
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other.....

Address..... Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-A

06450

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:

County

Carroll

City or town

7119 West End Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/2 mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Adam Clark Smith

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

Widower

6. (b) Name of husband or wife

Sarah Alice Smith

7. Birth date of deceased (mo., day, yr.)

October 7 1867

(c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

78

3

16

hrs.

min.

9. Birthplace

Town, county, and state

Freelands

Maryland

10. Usual occupation

Retired Farmer

11. Industry or business

FATHER

12. Name

Daniel Smith

MOTHER

13. Birthplace

Maryland

14. Maiden name

Margaret Walker

15. Birthplace

Maryland

16. Informant

J. Vernon Smith

Address

Hampstead Md

17. ~~Funeral~~ Burial

(Burial, cremation, or removal of body)

Date thereof

Jan 25-1946

(month) (day) (year)

Cemetery or crematory

St Peters Bldg Co Md

Location

Williams Md P.D.

18. Funeral director

H. G. Lingle

Address

Glen Rock Pa

19. Date: 24

1946

Mrs W. P. S. Denner

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Carroll

City or town

Hampstead

Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

—

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 23 1946, et 7 1/2 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 19 1946, to January 23 1946,

and that I last saw him alive on January 18 1946.

Immediate cause of death

Stroke Myocarditis

DURATION

Due to: Asthma Schistosomiasis

varicose veins

Due to:

Other conditions

(Include pregnancy within 8 months of death)

Major findings all operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

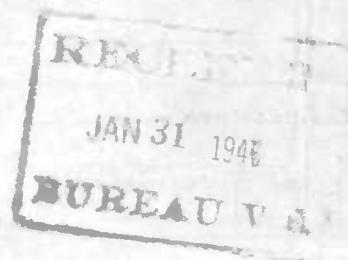
Joseph E. Bresn M.D.

M. D. or other

Address

Hampstead Md

Date signed 1-23-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

00433

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH:

County CarrollCity or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

L. Roberta Smith4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Benjamin M. Smith7. Birth date of deceased (mo., day, yr.) Sept 20 - 1874 6. (c) If alive, give age years8. AGE: Years 71 Months 3 Days 14 If less than one day hrs. min.9. Birthplace Frederick Co Maryland (Town, county, and state)10. Usual occupation Housewife11. Industry or business At Home12. Name Anna V. Egle13. Birthplace Maryland14. Maiden name Maria Sowers15. Birthplace Maryland16. Informant Mrs. Isabella AndersAddress Union Bridge Maryland17. Burial Date thereof Jan 6 - 1946 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Pine Creek CemeteryLocation New Martinsburg Maryland18. Funeral director D. D. Hartnett SonAddress Union Bridge New Windsor andJan. 6 1946 Elizur Legg RegistrarDate rec'd by registrar Elizur LeggMeans of injury Injured at work?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarrollCity or town Union Bridge (If outside city or town limits, write RURAL and give nearest town)Street No. Main Street (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 1946 at 7:45 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 6 1945 to Jan 4 1946, and that I last saw her alive on Jan 3 1946.Immediate cause of death Carcinoma of breast DURATIONDue to Due to Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE D. H. Legg M. D. or other Address Union Bridge Date signed 1-5-46

RECEIVED
JAN 17 1946
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3rd

00434

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Alberta Catherine Stouch

4. Sex

Fr

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife

Joseph Stouch

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 29 - 1865

8. AGE:

Years

80

Months

9

Days

26

If less than one day

hrs.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual occupation

Farm

11. Industry or business

MOTHER

FATHER

12. Name

John Geiselman

13. Birthplace

Littlestown, Pa.

14. Maiden name

Mary Garbrugh

15. Birthplace

Littlestown, Pa.

16. Informant

Mr. Lighton Byers

Address

Ryderwood, Balto Co. Md.

17. Burial

Date thereof Jan. 28 - 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Ward Cemetery

Location

Westminster, Md.

18. Funeral director

H. Bankard & Son

Address

Westminster, Md.

19. (Date rec'd by registrar)

1/26 1946 J. Woodward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 79 Penn. Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

Zone

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 25, 1946, at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 15 - 1946, to Jan 25, 1946, and that I last saw her alive on Jan 24, 1946.

Immediate cause of death

Acute Cardiac Dilatation -

DURATION

1/2 hr

Due to Chronic Myocarditis 272

Due to Chronic Bronchitis 102

Other conditions Tetanic Spasms - 202

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

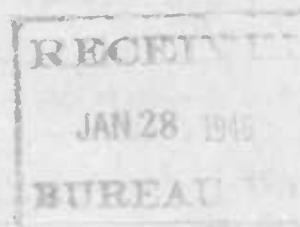
Injured at work?

23. SIGNATURE

Chas. R. Fout, M.D.

D. or other

Address Westminster, Md. Date signed 1-25-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

06435

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 months, 3 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 312 Worsley St.
(If rural, give LOCATION)

3. (a) FULL NAME
ROSA STREET

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	col.	single

6. (b) Name of husband or wife.

7. Birth date of deceased (mo. day, yr.) September 15, 1920

6. (c) If alive, give age years

8. AGE: Years	Months	Days	If less than one day
25	3	24	hrs. min.

9. Birthplace Crewe, Virginia
(Town, county, and state)
Worker in Sugar Factory

10. Usual occupation.

11. Industry or business

MOTHER FATHER
12. Name Sye Street
13. Birthplace Virginia

14. Maiden name Mary Oliver
15. Birthplace Virginia

16. Informant Reuben Hoffman, M.D.

Address Henryton, Maryland

17. Burial Date thereof Jan. 14, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ship to Crewe, Va.

Location

18. Funeral director Raynor Sanders

Address 1412 E. Preston St.

Jan. 9 1946

(Date rec'd by registrar) 19

Alfred P. Shaw, Jr.
Deputy Local Registrar

2. (a) If veteran, name war
3. (b) Social Security Number
Lost

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9, 1946, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6, 1945, to Jan. 9, 1946, and that I last saw her alive on January 9, 1946.

Immediate cause of death
Pulmonary Tuberculosis

DURATION
Oct. 1944

Due to.

Due to.

Other conditions.

(Include pregnancy within 3 months of death)

Major findings or operations.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

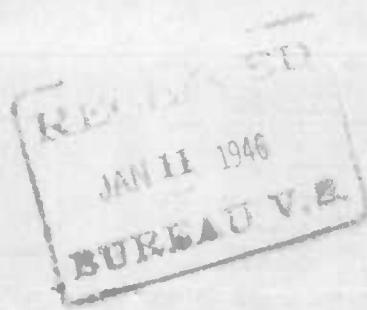
Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.

M. D. or other

1-9-46

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 75

00426

1. PLACE OF DEATH: Carroll.
 County
 City or town Manchester, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 yrs.
 Hospital, institution, or street address where death occurred: _____
 How long in hospital or institution? _____

3. (a) FULL NAME
SUSAN Lottey Walsh

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Widow

7. Birth date of deceased (mo., day, yr.) NOV 27 1870 8. (c) If alive, give age years

8. AGE: 75 Years 11 Months 15 Days If less than one day hrs. min.

9. Birthplace Manchester, Md. (Town, county, and state)

10. Usual occupation. Name

11. Industry or business John Thomas, Virginia

MOTHER FATHER 12. Name John Thomas, Virginia 13. Birthplace Manchester, Md.

MOTHER 14. Maiden name Louise 15. Birthplace Union Mills, Md.

16. Informant Mrs. Walter Stephan Address Manchester, Md.

17. Burial Burial Date thereof 12/15/46 (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)

Cemetery or crematory Cemetery Location Manchester, Md.

18. Funeral director Jacob Winkler Sons Address Manchester, Md.

19. Date rec'd by registrar JAN. 12 1946 M.D. or other M. D. or other
 (Date rec'd by registrar) Address Manchester, Md. Date signed 1-11-46
 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
 State Maryland County Carroll
 City or town Manchester, Maryland (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____ (If rural, give LOCATION)

2.(a) If veteran, name war. _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 1946 at 7:50 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 22 1945 to January 11 1946 and that I last saw her alive on January 10 1946.

Immediate cause of death Chronic Myocarditis DURATION ?

Due to _____

Due to _____

Other conditions Partial intestinal obstruction due to post operative adhesions (Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____ PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

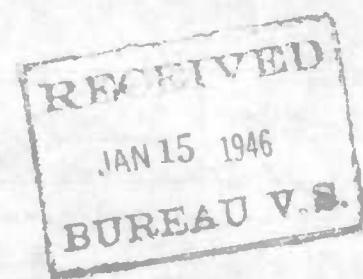
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Joseph E. Bush M. D. or other M. D. or other

Address Manchester, Md. Date signed 1-11-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00437

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

Carroll

County

Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 yrs. 8 mo. 6 da.

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 16 yrs. 8 mo. 6 da.

3. (a) FULL NAME

ANTONIA WALSKY

3. (b) Social Security Number

4. Sex

5. Color or race

B.(a) Single, married, widowed, or divorced

female

white

married

B.(b) Name of husband or wife Martin Walsky

Address unknown

6.(c) If alive, give age unknown years

7. Birth date of

deceased (mo., day, yr.) September 19, 1888

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace Russia

(Town, county, and state)

10. Usual occupation housewife

11. Industry or business home

FATHER 12. Name unknown

13. Birthplace Russia

MOTHER 14. Maiden name Unknown

15. Birthplace Russia

16. Informant Hospital Records

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?)

Date thereof Jan. 28/46
(month) (day) (year)

Cemetery or crematory

Location New Cathedral Cemetery Edmondson Ave

18. Funeral Director

Address John J. Miller

2334 Jefferson St.

Jan. 23, 1946

C. Cherrywell

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 536 South Paca Street

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan. 23rd. 1946 at 8.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 17 1929, to Jan 23 1946

and that I last saw her alive on Jan. 23 1946

Immediate cause of death

Carcinoma of the sigmoid
flexure of the colon

Due to

DURATION

1 yr.

Due to

Schizophrenia

Other conditions

19 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, Industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Sykesville, Md. Date signed 1-23-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

00438

Reg. Dist. No. 70

1. PLACE OF DEATH:

County CarrollCity or town Jamesstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Jannie B. Wantz

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

married

6. (b) Name of husband or wife

J. Thomas Wantz

7. Birth date of deceased (mo., day, yr.)

July 5, 1874

6. (c) If alive, give age years

8. AGE:

Years
71Months
6Days
14If less than one day
hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

MOTHER FATHER

12. Name Samuel J. Hall

13. Birthplace

Maryland

14. Maiden name

Mary J. Hall Fair

15. Birthplace

Maryland

16. Informant

J. Thomas Wantz

Address

Jamesstown, Md.

17. Burial

Date thereof Jan 21, 1945

(Burial, cremation, or removal? Which?)

(month) (day) (year)

Cemetery or crematory

Lutheran Cemetery

Location

Jamesstown, Maryland

18. Funeral director

C. O. Fuss & Son

Address

Jamesstown, Maryland

19. Date rec'd by registrar

Jan 21, 1946 Ethel M. Mehling

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty CarrollCity or town Jamesstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 19

19

at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19...

to 19...

and that I last saw him alive on 19...

19...

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, Industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Samuel J. Hall Deputy Medical Examiner

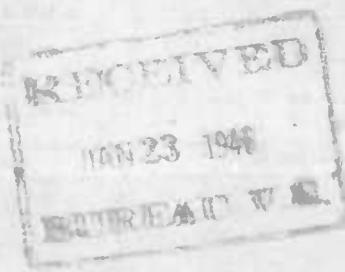
M. D. or other

Address

Westminster, Md.

Date signed

1/19/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 115-1

CERTIFICATE OF DEATH

00439

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: *Carroll*
County *Manchester* MD

City or town *Manchester* (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *29 years*

Hospital, institution, or street address where death occurred

How long in hospital or institution?

3. (a) FULL NAME

Alice H. Warehime

4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*

8. (b) Name of husband or wife *Jacob W. Warehime*

7. Birth date of deceased (mo., day, yr.) *Aug. 8, 1867* 8. (c) If alive, give age *81* years

8. AGE: Years *78* Months *5* Days *2* If less than one day
hrs. *0* min. *0*

9. Birthplace *Maryland* (Town, county, and state)

10. Usual occupation *House Wife*

11. Industry or business *Valentines Manchester*

12. Name *Maryland*

13. Birthplace *Maryland*

14. Maiden name *Heisteretta Grumine*

15. Birthplace *Maryland*

16. Informant *Jacob W. Warehime*

Address *Manchester MD*

17. Burial *Burial* Date thereof *1-13-46*
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory *Cemetery*

Location *Manchester MD*

18. Funeral director *Jacob W. Warehime*

Address *Manchester MD*

19. Date rec'd by registrar *Jan. 11, 1946*

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Carroll*

City or town *Manchester* (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number *✓*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Jan. 10, 1946*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 3, 1946 to *Jan. 10, 1946*

and that I last saw h *alive* on *Jan. 9, 1946*

Immediate cause of death

Septicemia DURATION *7 days*

Due to *Peritonitis Abscess* DURATION *7 days*

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

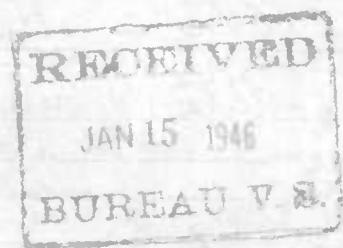
Means of injury

Injured at work?

23. SIGNATURE *Jas. E. Bush M.D.*

M. D. or other

Address *Hampstead MD* Date signed *1/11/46*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

00440

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

Carroll

County

Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 yrs. 8 mo. 10 da.

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 19 yrs. 8 mo. 10 da.

3. (a) FULL NAME

LENA WEIBEL (Waibel)

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female white widowed

B. (b) Name of husband or wife (unknown) Weibel (Waibel)

unkn.

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Exact date unknown (1862)

8. AGE: Years Months Days If less than one day
84 hrs. min.9. Birthplace Maryland (town unknown)
(Town, county, and state)

10. Usual occupation none

11. Industry or business none

MOTHER FATHER 12. Name Unknown

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Hospital Records

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal, Which?)

Date thereof Jan. 20 1946
(month) (day) (year)

Cemetery or crematory Western Cemetery

Location Baltimore, Md.

18. Funeral director Harry W. Wetzel

Address 20th & E. 12th Sts.

19. Jan. 28 1946 C. Harry Zeller

Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1805 Whittmore Avenue

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2d. DATE OF DEATH January 27 1946 at 3:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 1926, to Jan. 27, 1946

end that I last saw her alive on January 26, 1946

Immediate cause of death Gangrene (arteriosclerotic) of the left foot

DURATION

1 mo.

Due to

Due to

Other conditions General arteriosclerosis 20 year

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Maud M. Rose M.D. M. D. or other

Address Sykesville, Md. Date signed Jan. 27, 1946

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

EDUCATIONAL INSTITUTE

RECEIVED

JAN 31 1946

BUREAU V.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

00441

74

Reg. Dist. No.

1. PLACE OF DEATH:
County Carroll

City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 28 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?

3. (a) FULL NAME
ALBERT WILSON

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	widowed

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo. day, yr.) July 10, 1910
.....(c) If alive, give age.....years

8. AGE: Years	Months	Days	If less than one day
35	6	12hrs.min.

9. Birthplace..... Cumberland County, N.C.
(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business

MOTHER FATHER
12. Name..... Unknown
13. Birthplace..... Unknown

14. Maiden name..... Bettie ?
15. Birthplace..... Unknown

16. Informant..... Reuben Hoffman, M.D.
Address..... Henryton, Maryland

17. Date thereof..... 1/25/46
(Burial, cremation, or removal. Which?)
Cemetery or crematory..... Removed from Balto. City

Location..... morgue to Dunn, N. C.
by..... O. E. Payton
18. Funeral director
Address..... Dunn, N. C.

Jan. 22, 1946
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County.....

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 712 Aisquith Street
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number
719-18-5707

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22, 1946, at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 24, 1945, to Jan. 22, 1946, and that I last saw him alive on Jan. 22, 1946.

Immediate cause of death..... Pulmonary Tuberculosis

DURATION
August 1943

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

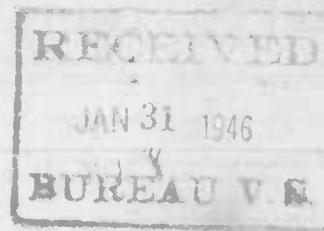
Where did injury occur?..... (City or town) (County) (State)

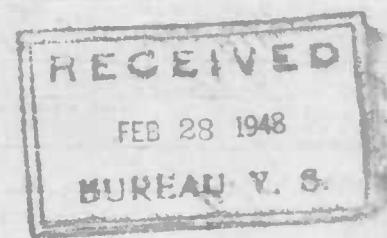
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Reuben Hoffman, M.D.
M. D. or other

Address..... Henryton, Maryland
Date signed 1-22-46





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

CERTIFICATE OF DEATH

Reg. Dist. No. 00481

1. PLACE OF DEATH:

County

Carroll

City or town

Union Bridge Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Unknown

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Edmund Gungling

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Mrs. Ella Gungling

7. Birth date of deceased (mo. day, yr.) August 12 - 1867

8. AGE: Years Months Days If less than one day
78 4 29 hrs. min.9. Birthplace Carroll County, Maryland
(Town, county and state)

10. Usual occupation Farmer

11. Industry or business Retired

12. Name Edmund Gungling

13. Birthplace Maryland

14. Maiden name Agnes Amatz

15. Birthplace Pennsylvania

16. Informant Mrs. Ella Gungling

Address Union Bridge Mill - R.R. 1

17. Burial Date thereof Jan. 14, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Huntstown Maryland

18. Funeral director D. D. Hart & Son

Address Union Bridge & New Maryland Rd

19. Jan. 12, 1946
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Carroll

City or town Union Bridge Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Back Hill

(If rural, give LOCATION)

2. (a) If veteran, name war None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11, 1946, at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6, 1945, to Jan. 11, 1946,

and that I last saw him alive on Jan. 11, 1946.

Immediate cause of death

Chronic myocarditis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. J. Egg M. D. or other

Address Union Bridge & New Maryland Rd Date signed Jan. 12, 1946

